PATIENT INFORMATION FOR PATIENTS

Date_____

Patient's name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (Zip)

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies _____

Parent or guardian name _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____ (Last) _____ (First) _____ (Middle)

Residence _____ (Street) _____ (City) _____ (Zip)

Mailing Address_____ (Street) _____ (City) _____ (Zip)

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address _____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____ (Street) _____ (City) _____ (Zip)

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

Yes	No	Is the patient taking any medication? _____
Yes	No	Is the patient allergic to any medication? _____
Yes	No	History of a major illness? _____
Yes	No	Has the patient had any operations? _____
Yes	No	Ever been involved in a serious accident? _____
Yes	No	Have seen a physician in the last 12 months? Why? _____
		Female Patients only:
Yes	No	Has menstruation started? _____
Yes	No	Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes	No	Is the patient presently in any dental pain? _____
Yes	No	Ever experienced any unfavorable reaction to dentistry? _____
Yes	No	Has the patient ever lost or chipped any teeth? _____
Yes	No	Have there been any injuries to face, mouth, or teeth? _____
Yes	No	Is any part of your mouth sensitive to temperature? Where? _____
Yes	No	Is any part of your mouth sensitive to pressure? Where? _____
Yes	No	Do gums bleed when brushing? _____
Yes	No	Any type of thumb or tongue habit? _____
Yes	No	Is the patient a mouth breather? _____
Yes	No	Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes	No	What is the patient's attitude toward receiving orthodontic treatment? _____
Yes	No	Has anyone in the family received orthodontic treatment? _____
		How did they feel about the result? _____
Yes	No	Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes	No	Experience jaw clicking or popping? _____
Yes	No	Aware of clenching or grinding teeth during the day? _____
Yes	No	Experience "tension" headaches? _____
Yes	No	Has the patient ever experienced chronic ringing in the ears? _____
Yes	No	Does the patient need extra help with instructions? _____
Yes	No	Is the patient sensitive or self-conscious about his/her teeth? _____
Yes	No	Height of parents? Mom_____ Dad_____
Yes	No	Are you aware that some appointments will be during school hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____